TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Fondren Orthopedic

Respondent Name
New Hampshire Insurance Co

MFDR Tracking Number
M4-16-0933-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
December 10, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We have received an explanation of benefits denying the claim for the above date of service. We have sent a corrected claim showing that we added the G codes to this claim however the claim was still denied. We are asking that you reconsider this claim and send us the payment we are scheduled for."

Amount in Dispute: $215.23

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Please see the EOBs. The bill was first reviewed and denied "required function-related G-codes or modifiers not included on the bill… The bill was reconsidered with new information and denied "This is a bundled or non covered procedure based on Medicare PFS guidelines no separate payment allowed."

Response Submitted by: Flahive, Ogden, & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 17, 2015	97002 -59 –GP, 97140 –GP, 97110 -GP	$215.23	$182.12

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for professional medical services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment

codes:

- 4 – The procedure code is inconsistent with the modifier used or a required modifier is missing
- BL – This bill is a reconsideration of a previously reviewed bill
- 234 – This procedure is not paid separately

Issues

1. Was the respondent's position statement supported?
2. Are the insurance carrier's reasons for denial or reduction of payment supported?
3. What is the applicable rule that pertains to reimbursement?
4. Is the requestor entitled to additional reimbursement?

Findings

1. The respondents states, "The bill was reconsidered with new information and denied "This is a bundled or non covered procedure based on Medicare PFS guidelines no separate payment allowed." Review of the submitted documents finds insufficient evidence to support this denial. Therefore, this dispute will be reviewed based on information available to the Division.

2. The insurance carrier denied disputed services with claim adjustment reason code 4 – "The procedure code is inconsistent with the modifier used or a required modifier is missing." 28 Texas Administrative Code §134.203 (b) requires that,

   > For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following:
   >
   > > (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers;

   Review of the applicable Medicare payment policy found at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c05.pdf Medicare Claims Processing Manual, Chapter 5 - Part B Outpatient Rehabilitation and CORF/OPT Services which states,

   > *G. Required Reporting of Functional G-codes and Severity Modifiers*
   >
   > *The functional G-codes and severity modifiers listed above are used in the required reporting on therapy claims at certain specified points during therapy episodes of care. Claims containing these functional G-codes must also contain another billable and separately payable (non-bundled) service. Only one functional limitation shall be reported at a given time for each related therapy plan of care (POC).*

   Review of the submitted documentation finds the services in dispute did include the "GP" modifier on the claim. A claim and denial was found for the G-codes, G8984 and G8985. The requestor met the requirements of Rule 134.203(b).

   The insurance carrier's denial reason is not supported. The disputed services will therefore be reviewed per applicable Division rules and fee guidelines.

3. 28 Texas Administrative Code §134.203 (c) states,

   > To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications.
   >
   > > (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is (date of service yearly conversion factor).

   The services in dispute will be calculated as follows;

   - Procedure code 97002, service date June 17, 2015. The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the

conversion factor. The MAR is calculated by substituting the Division conversion factor. For this procedure, the relative value (RVU) for work of 0.6 multiplied by the geographic practice cost index (GPCI) for work of 1.019 is 0.6114. The practice expense (PE) RVU of 0.56 multiplied by the PE GPCI of 1.006 is 0.56336. The malpractice RVU of 0.02 multiplied by the malpractice GPCI of 0.955 is 0.0191. The sum of 1.19386 is multiplied by the Division conversion factor of $56.20 for a MAR of $67.09. Per Medicare policy, when more than one unit of designated therapy services is performed on the same day, full payment is made for the first unit of the procedure with the highest practice expense. Payment for each subsequent unit is reduced by 50% of the practice expense. This procedure has the highest PE for this date. The first unit is paid at $67.09. This service was performed in a designated workers' compensation underserved area listed in §134.2; per §134.203(b)(2), a 10% incentive payment is added to the MAR for a total of $73.80.

- Procedure code 97140, service date June 17, 2015. The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the Division conversion factor. For this procedure, the relative value (RVU) for work of 0.43 multiplied by the geographic practice cost index (GPCI) for work of 1.019 is 0.43817. The practice expense (PE) RVU of 0.4 multiplied by the PE GPCI of 1.006 is 0.4024. The malpractice RVU of 0.01 multiplied by the malpractice GPCI of 0.955 is 0.00955. The sum of 0.85012 is multiplied by the Division conversion factor of $56.20 for a MAR of $47.78. Per Medicare policy, when more than one unit of designated therapy services is performed on the same day, full payment is made for the first unit of the procedure with the highest practice expense. Payment for each subsequent unit is reduced by 50% of the practice expense. This procedure does not have the highest PE for this date. The PE reduced rate is $36.47. This service was performed in a designated workers' compensation underserved area listed in §134.2; per §134.203(b)(2), a 10% incentive payment is added to the MAR for a total of $40.12.
- Procedure code 97110, service date June 17, 2015. The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the Division conversion factor. For this procedure, the relative value (RVU) for work of 0.45 multiplied by the geographic practice cost index (GPCI) for work of 1.019 is 0.45855. The practice expense (PE) RVU of 0.44 multiplied by the PE GPCI of 1.006 is 0.44264. The malpractice RVU of 0.02 multiplied by the malpractice GPCI of 0.955 is 0.0191. The sum of 0.92029 is multiplied by the Division conversion factor of $56.20 for a MAR of $51.72. Per Medicare policy, when more than one unit of designated therapy services is performed on the same day, full payment is made for the first unit of the procedure with the highest practice expense. Payment for each subsequent unit is reduced by 50% of the practice expense. This procedure does not have the highest PE for this date. The PE reduced rate is $39.28 at 2 units is $78.56. This service was performed in a designated workers' compensation underserved area listed in §134.2; per §134.203(b)(2), a 10% incentive payment is added to the MAR for a total of $86.42.

4. The total allowable reimbursement for the services in dispute is $182.12. This amount less the amount previously paid by the insurance carrier of $0.00 leaves an amount due to the requestor of $182.12. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $182.12.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $182.12 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

		December , 2015
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.